Name:_____ Date of birth:_____
**Last First Middle** M D Yr
Address:〒_____
Telephone: Home_____Office_____Emergency_____
Your or your husband's occupation:_____
Place of employment:_____
Height:_____Weight:_____Blood type:_____Rh (____)

1. Your problem or reason for this visit:_____
2. How long have you had this problem?_____
3. When was your last period? From_____To_____
4. What is your menstrual cycle? 25_____28_____30_____Irregular_____
5. Are you married? Yes_____No_____
   If yes, how old were you when you got married? Age_____
   If not married, do you have sexual intercourse experience? Yes_____No____
   If not married, do you have a sexual intercourse partner? Yes_____No_____
6. Have you ever become pregnant? Yes_____No_____
   If yes, how many times? 1_____2_____3_____Or more_____
7. Have you ever delivered baby? Yes_____No_____
   If yes, 1st baby in_____(Yr) 2nd baby in_____(Yr) 3rd baby in_____(Yr)
8. Method of delivery: Natural_____C/S_____
   Other_____
9. Have you ever had a miscarriage or termination? Yes_____No_____
   If yes, miscarriage in_____(Yr) termination in_____(Yr)
10. Are you taking contraceptive pills now? Yes_____No_____
    If yes, how long?_____ If you have taken before, when?_____
11. Medical history_____
12. Family history _____
13. Drug allergy: Yes_____No_____Name of drug_____
14. Current medication (including over-the-counter drugs)
    _____
15. Is the detailed statement necessary (written in Japanese) ? Yes_____No____

Referred to us by: _____

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